PLAN DESIGN & BENEFITS - "**HMO**"
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	PREFERRED CARE
Deductible (per calendar year)	$200 Individual $400 Family
All covered expenses, excluding prescription drugs, accumulate toward the preferred Deductible. Unless otherwise indicated, the Deductible must be met prior to benefits being payable. The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Deductible amount.	
Member Coinsurance	Covered 100%
Member Payment Limit (per calendar year)	$2,200 Individual $4,400 Family
Certain member cost sharing elements may not apply toward the Member Payment Limit. Only those out-of-pocket expenses resulting from the application of medical copays, deductible, and coinsurance percentage may be used to satisfy the Payment Limit. Pharmacy expenses apply towards the Member Payment Limit. The family Member Payment Limit is a cumulative Member Payment Limit for all family members. The family Member Payment Limit can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Member Payment Limit amount	
Lifetime Maximum	Unlimited except where otherwise indicated.
Primary Care Physician Selection	Required
Referral Requirement	Required
PREVENTIVE CARE	**PREFERRED CARE**
Routine Adult Physical Exams/ Immunizations 1 exam per 12 months for members age 22 and older	Covered 100%; deductible waived
Routine Well Child Exams/Immunizations 7 exams in the 1st 12 months of life, 3 exams in the 2nd 12 months of life, 3 exams in the 3rd 12 months of life, 1 exam per 12 months thereafter to age 22; age 22 to 65+, 1 exam every 12 months.	Covered 100%; deductible waived
Routine Gynecological Care Exams Includes routine tests and related lab fees	Covered 100%; deductible waived
Routine Mammograms	Covered 100%; deductible waived
Women's Health Includes: Screening for gestational diabetes, HPV (Human Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for Human Immunodeficiency Virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies, and counseling. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.	Covered 100%; deductible waived
Routine Digital Rectal Exam / Prostate-specific Antigen Test	Covered 100%; deductible waived
Colorectal Cancer Screening For all members age 50 and over.	Covered 100%; deductible waived
Routine Hearing Screenings	Covered 100%; deductible waived
PHYSICIAN SERVICES	**PREFERRED CARE**
Office Visits to PCP Includes services of an internist, general physician, family practitioner or pediatrician.	$15 office visit copay; deductible waived
Specialist Office Visits	$15 office visit copay; deductible waived
Pre-Natal Maternity Office Visits	Covered 100%; deductible waived
Maternity Care	$15 office visit copay; deductible waived

E-Visit (Teladoc)	$15 copay; deductible waived
Allergy Testing	Covered as either PCP or specialist office visit
Allergy Injections	Covered as either PCP or specialist office visit
Audiometric Hearing Exam 1 routine exam per 24 months.	$15 office visit copay; deductible waived
DIAGNOSTIC PROCEDURES	**PREFERRED CARE**
Diagnostic Laboratory If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing	Covered 100%; deductible waived
Diagnostic X-ray	$15 office visit copay; deductible waived
EMERGENCY MEDICAL CARE	**PREFERRED CARE**
Urgent Care Provider (benefit availability may vary by location)	$50 copay; deductible waived
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room	$75 copay; deductible waived
Non-Emergency care in an Emergency Room	Not Covered
Ambulance	Covered 100%; after deductible
HOSPITAL CARE	**PREFERRED CARE**
Inpatient Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	Covered 100%; after deductible
Inpatient Maternity Coverage (includes delivery and postpartum care) The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	Covered 100%; after deductible
Outpatient Surgery	Covered 100%; after deductible
Outpatient Hospital Expenses (excluding surgery) The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit	Covered 100% after deductible
MENTAL HEALTH SERVICES	**PREFERRED CARE**
Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	Covered 100%; after deductible
Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit	$15 copay; deductible waived
ALCOHOL/DRUG ABUSE SERVICES	**PREFERRED CARE**
Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	Covered 100%; after deductible
Outpatient The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit	$15 copay; deductible waived
OTHER SERVICES	**PREFERRED CARE**
Convalescent Facility The member cost sharing applies to all covered benefits incurring during a member's inpatient stay.	Covered 100%; after deductible
Home Health Care Includes Private Duty Nursing limited to 70 eight hour shifts per calendar year. Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.	Covered 100%; after deductible
Hospice Care - Inpatient Aetna Compassionate Care (ACCP) - Enrollment available to members with a 12 month terminal prognosis. Members may be eligible to continue receiving curative care. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	Covered 100%; after deductible
Hospice Care - Outpatient Aetna Compassionate Care (ACCP) - Enrollment available to members with a 12 month terminal prognosis. Members may be eligible to continue receiving curative care. The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	Covered 100%; after deductible

Outpatient Short-Term Rehabilitation Includes Speech, Physical and Occupational Therapy.	$15 copay; deductible waived
Spinal Manipulation Therapy	$15 copay; deductible waived
Acupuncture Therapy	$15 copay; deductible waived
Durable Medical Equipment	Covered 100%; after deductible
Diabetic Supplies	Covered same as any other medical expense.
Autism	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Covered the same as any other expense. Applied Behavioral Analysis, Behavorial Therapy, Physical, Occupational and Speech Therapy for the treatment of Autism covered with no visit limits or age restrictions.	
Hearing Aids (Limited to $5,000 per calendar year)	Covered 100%; after deductible
Contraceptive drugs and devices not obtainable at a pharmacy (includes coverage for contraceptive visits)	Covered 100%; deductible waived
Generic FDA-approved Women's Contraceptives	Covered 100%; deductible waived
Transplants Coverage is provided at an Institute of Excellence (IOE) contracted facility only.	Covered 100%; after deductible
Bariatric Surgery The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	Covered 100%; after deductible
Gender Reassignment Surgery The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	Covered 100%; after deductible
Mouth, Jaws and Teeth	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Out of Area Dependents	No coverage for non-emergency care received outside the service area.
FAMILY PLANNING	**PREFERRED CARE**
Infertility Treatment Diagnosis and treatment of the underlying medical condition.	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Vasectomy	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Tubal Ligation	Covered 100%; deductible waived
PHARMACY	**PREFERRED CARE**
Retail	$10 copay for generic drugs, $25 copay for formulary brand-name drugs, and $40 copay for non-formulary brand-name drugs up to a 30 day supply at participating pharmacies.
Mail Order	$20 copay for generic drugs, $50 copay for formulary brand-name drugs, and $80 copay for non-formulary brand-name drugs up to a 31-90 day supply from Aetna Rx Home Delivery®.
Aetna Specialty Pharmacy® First prescription fill at any retail or mail order drug facility. Subsequent fills must be through Aetna Specialty Pharmacy®	
Generic maintenance drugs covered at 100% for asthma, diabetes, hyperlipidemia, hypertension, and heart disease.	
Plan Includes: Oral Contraceptives covered 100% for Generic, Brand, and All Prescribed forms of birth control. Oral and injectable fertility drugs, and Diabetic supplies.	
Performance Enhancement Medication (8 tablets/month).	
Precert for growth hormones included	
Formulary generic FDA-approved Women’s Contraceptives covered 100% in network.	

PLAN DESIGN & BENEFITS - "**HMO**"
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 26

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents; Charges related to any eye surgery mainly to correct refractive errors; Cosmetic surgery, including breast reduction; Custodial care; Dental care and X-rays; Donor egg retrieval; Experimental and investigational procedures; Hearing aids; Immunizations for travel or work; Infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents;

Nonmedically necessary services or supplies; Orthotics; Over-the-counter medications and supplies; Reversal of sterilization; Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and special duty nursing. Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care services and, therefore, cannot guarantee results or outcomes. Consult the plan documents (i.e. Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitation relating to the plan. With the exception of Aetna Rx Home Delivery, all preferred providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice.

Some benefits are subject to limitations or visit maximums. Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. Some of the benefits requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). When the Member’s preferred provider is coordinating care, the preferred provider will obtain the precertification. When the member utilizes a non-preferred provider, Member must obtain the precertification. Precertification requirements may vary. Depending on the plan selected, new prescription drugs not yet reviewed by our medication review committee are either available under plans with an open formulary or excluded from coverage unless a medical exception is obtained under plans that use a closed formulary.

They may also be subject to precertification or step-therapy. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received after open enrollment) are not covered, and medical exceptions are not available for them. While this information is believed to be accurate as of the print date, it is subject to change.

Plans are administered by Aetna Life Insurance Company.